STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
			B. WING		02/06/2015
		l .		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF	R		16TH ST	
CDOWNI	POINTE OF INDIAN	NAPOLIS		IAPOLIS, IN 46219	
CROWN	FOINTE OF INDIAI	NAFOLIS	INDIAN	AFOLIS, IN 402 19	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
R000000					
	This visit was fo	or the Investigation of	R000000		
	Complaints IN0	0163773 and			
	IN00163911.				
	11100103711.				
	Complaint IN00163773- Substantiated.				
	•				
		ated to the allegations are			
	cited at R268 an	d R270.			
	Complaint IN00163911- Substantiated.				
No deficiencies related to the allegations					
	are cited.				
	Survey Dates: Fo	ebruary 4, 5, and 6, 2015			
	,				
	Facility number:	005729			
	Provider number				
	AIM number: N	A			
	Survey team:				
	Chuck Stevenson	n RN			
	Census bed type	:			
	Residential: 60				
	Total: 60				
	10101.00				
	Conque nover to	no:			
	Census payor ty	pc.			
	Medicaid: 58				
	Other: 2				
	Total: 60				
	Sample: 8				
	Sumpre. 0				
				1	I

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

State Form Event ID: MFG111 Facility ID: 005729 If continuation sheet Page 1 of 12

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED		
			B. WING		02/06/2015		
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE			
CDOM/NI	DOINTE OF INDIAN	JADOLIS		E 16TH ST			
	POINTE OF INDIAN			NAPOLIS, IN 46219			
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)		
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA	ATE COMPLETION DATE		
1710	These state findi	· · · · · · · · · · · · · · · · · · ·	1710		BATE		
		410 IAC 16.2-5.					
	decordance with 410 11to 10.2 3.						
	 Ouality review c	completed on February					
		eryl Fielden, RN.					
	12, 2011 by energit folders, i.e. v.						
R000268	410 IAC 16.2-5-5.	` '					
		nal Services - Deficiency					
	(a) The facility shall provide, arrange, or make available three (3) well-planned meals						
		lays a week that provide a					
		ion of the daily nutritional					
	requirements.	ravian and interview	R000268	RE: 0268 Submission of this	plan 02/27/2015		
		review and interview,	K000208	of correction does not constitu	02/2//2016		
	1	d to ensure adequate ovided through daily		admission of quilt All resider			
	_	or 60 residents who		the facility would be at risk for	the		
	participate in fac			potential of harm by such deficiency No residents were			
	population of 60			found to be harmed . As I			
		•		reported on 1/9/15 our facility	I		
	Findings include	.		experienced water damage in kitchen this was due to severa	I		
	1 mamgs merade	··		frozen pipes bursting this	aı		
	A facility "Incid	ent Report Form" dated		happened in the early morning	ng		
	1	5 A.M., and reported to		hours of 1/9/15 for breakfast			
		a State Department of		served a cold meal of cereals rolls, juice coffee and milk for	I		
	Health) on that of	_		lunch as were still trying to ga			
	,	,		things together and set up a			
	"HFA (Health Fa	acility Administrator)		make shift area for food	ot		
	`	m LPN stating that water		preparation until we knew what had happened and what was	aı		
		from under the kitchen		going to happen so I ordered			
		ing roomRoom trays		pizzas out we had pizza and	I		
		serve meals until		salads and fruit with drinks b dinner time we had secured a	•		
	ceiling repair is			new location in the building w			
	kitchen."	_		was the activity area which ha	I		
				tables and ample light and			

State Form Event ID: MFG111 Facility ID: 005729 If continuation sheet Page 2 of 12

AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:					
	IDEI (III ICITITO) (I (CIMBER)	A. BUILI	DINC	00	COMPL	ETED
		B. WING			02/06/	2015
		D. WING		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPI	ER			16TH ST		
CROWNPOINTE OF INI	ANAPOLIS			APOLIS, IN 46219		
(X4) ID SUMMA	STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX (EACH DEFI	ENCY MUST BE PRECEDED BY FULL	P	PREFIX			COMPLETION
TAG REGULATOR	OR LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
The HFA was 1:00 P.M. She hours of 1/09 the facility specified external suffered ext	interviewed on 2/04/15 at indicated that in the early 15 a water pipe servicing inkler system burst, tchen and portions of the indicated the kitchen sive damage rendering it use and requiring major cluding removal and repair paration equipment, eplacement of drywall, and irs to electrical and ices. She indicated that turn the kitchen to service			refrigerator, roasters and our for supplier brought us a portable oven and two deep well portable devices for preparing food all food was prepared and package for room delivery this process continued for several days unto we were able to build a new activity kitchen on the second floor with a deep well sink, long counter with table top prepared and a residential electric stove and refrigerator we had met wour food supplier rep and additional prepared foods were made available to us on our or guide and we began to prepared our meals in the temporary kitchen, these meals were modified from our regular approved menus by utilizing prepared foods such as Salisbury steak with gravy alresprepared and all we needed to was to heat temp and serve since were still unable to cook anything on the stove top due the lack of ability to utilize the machine or the 3 bay deep we sink we were unable to proper clean cookware so all preparation is done in disposary pans were able to utilizes tubs clean our utensils via the 3 stemethod. At the time of the visi had not yet resubmitted the modified menus to the register dietician. The surveyor asked our nutritional analysis of our menus and we were unable to supply that to him due to the fat that we do not compute the	ple ged il gea vith eder e eady odo to dish Il rly able to pt for	

State Form Event ID: MFG111 Facility ID: 005729 If continuation sheet Page 3 of 12

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPL	ETED
			A. BUIL			02/06/	2015
			B. WING		DDDECC CITY CTATE 7ID CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
ODOMA	DOINITE OF INIDIAN	IABOLIO			16TH ST		
CROWN	POINTE OF INDIAN	NAPOLIS		INDIAN	APOLIS, IN 46219		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	the available ove	en. She indicated that			analysis that is done by the		
menus had been changed to reflect the					registered dietician My error w		
	use of prepared	foods.			that I had not sent the modified		
	During an interview with the Food				menus to the dietician for reviet to ensure that adequate nutrition		
					was being provided.	JII	
	_				I immediately sent the menus	that	
	Service Supervisor on 2/05/15 at 1:20 P.M., with the HFA present, she				the dietary manger had put		
					together to the Dietician and		
	indicated the new menus had been				Armstrong Nutritional Services	for	
	created "based on what we had before."				her review. Those menus		
	She indicated the previous menus had				are attached for your review, s		
	been prepared by a Registered Dietitian				suggested to give the resident additional choice of protein iter		
	(R.D.), but the facility had no				for breakfast to add a Quaker	115	
		ted to the nutritional			Oatmeal Square or a Special R	<	
		hose menus. She also			protein cereal bar. we added the		
	-				Quaker Square as additional p		
		ritional analysis had been			of the normal breakfast service	9	
		us currently in use, and			along with the whole grain cold		
	which would ren	nain in use until the			cereal mile, juice and roll. She		
	facility's kitchen	was back in service. She			made a couple of other addition of fruit to the menus, but overa		
	additionally indi	cated breakfast was			stated that we had done a	III	
	limited to cold c	ereal with milk, juice,			good job of meeting the nutrition	onal	
		osed to the previous			needs of the residents The		
		pically included eggs,			signed menus are attached for		
		cream of wheat, and cold			your review. In addition to the		
		·			alternative of peanut butter		
	_	she indicated she was			sandwich's we have a fruit cup	we	
		ne change in breakfast			also have cottage cheese or a		
	_	ffect meeting daily			deli sandwich available. I do understand that my residents		
	nutritional requi	rements.			desire a broader menu as they	,	
					are used to , however due to o		
	The Account Re	presentative for the			limited space right now we are		
		y food service provider			unable to prepare them eggs		
		by phone on 2/05/15 at			made to order or hot grilled		
		dicated his company had			items. we have tried to serve		
					various breakfast casseroles		
		facility to provide			and the response was unfavorable Prior to serving o	ur	
	prepared foods t	he facility could use in			umavorable FIIOI to serving o	ui	

State Form Event ID: MFG111 Facility ID: 005729 If continuation sheet Page 4 of 12

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
			B. WING		02/06/2015	
NAME OF F	DDOMNED OF CURRY IED		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER		7365 E	16TH ST		
CROWN	POINTE OF INDIAN	IAPOLIS	INDIAN	IAPOLIS, IN 46219		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	· ·	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
		ion, and had scheduled		meals via room service we on	•	
	·	per week to help with		had approximately 60 % of ou residents who chose to come		
	storage issues, bu	ut indicated his company		the dining room for breakfast,		
	provided no nutr	itional information or		with room service we have 10		
	menus planning	services. He indicated		of our clients eating a breakfa	st	
	this was consider	red the responsibility of		now. Our original estimate of		
	the facility and tl	heir Registered Dietitian.		completion on renovations we 6-8 weeks out . As of today w		
	,	-		expect to back in our kitchen f		
	The facility's Re	gistered Dietitian was		functioning serving our norma	,	
	interviewed by phone on 2/05/15 at 2:15 P.M. She indicated she had not consulted			dietician approved menus by		
				2/27/15 which will be seven		
		concerning nutritional		weeks from the start of the flo	oa.	
	· ·	ne facility's altered				
		g whether the menus				
	would meet stand					
		ndicated she had an				
	* *	risit the facility on				
		isultation, but the facility				
		pointment, stating "things				
	"	mess." She indicated the				
	1	r to call back "around the				
		" to reschedule the				
	appointment.					
	_	iew on 2/06/15 at 12:30				
	P.M., the HFA in	ndicated the facility had				
	no written policy	and or procedure				
	related to nutrition	on and menu preparation				
	but relied on I.S.	D.H. published				
	standards for gui	dance and direction in				
	_	d dietary matters.				
		,				
	This Residential	tag relates to Complaint				
	IN 00163773.	o - Marie to Complaint				
	1					

State Form Event ID: MFG111 Facility ID: 005729 If continuation sheet Page 5 of 12

NAME OF PROVIDER OR SUPPLIER CROWNPOINTE OF INDIANAPOLIS (X4) ID (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				LDING G STREET A 7365 E	ADDRESS, CITY, STATE, ZIP CODE 16TH ST APOLIS, IN 46219 PROVIDER'S PLAN OF CORRECTION	(X3) DATE COMPL 02/06/	ETED
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
R000270	(c) The facility mus (1) daily dietary rewith consideration (2) reasonable relipersonal preference (3) the temporary to the resident 's Based on record the facility failed daily dietary requiperferences were reviewed for diet population of 60 H, and I.) Findings include A facility "Incide 1/09/2015 at 1:13 I.S.D.H. on that of "HFA (Health Fareceived call from was running out door into the dimare being used to ceiling repair is of kitchen."	all Services - Deficiency st meet: quirements and requests, of food allergies; gious, ethnic, and ses; and need for meals delivered room. review and interview, to ensure resident's airements, requests, and meet for 6 of 6 residents sary issues in a c (Residents D, E, F, G, the transfer of the transfe	R00	00270	RE:0270 Submission of this pof correction does not constitute admission of quilt. All resident the facility would be at risk for potential of harm by such deficiency. No residents were found to be harmed. As I reported on 1/9/15 our facility experienced water damage in kitchen this was due to several frozen pipes bursting, this rendered our kitchen and dinir out of service this happened if the early morning hours of 1/9/15 for breakfast we served cold meal of cereals, rolls, juic coffee and milk. We have now added a Quaker oatmeal squain addition to the items listed above. We also have had the normal peanut butter sandwich, or a fruit cup availate as an alternative to any main entrée e have added cottage cheese or a deli sandwich as well. These items are some of normal alternatives on our regmenus the only additional iter has been the deli sandwich. We attempted to serve the resider a routine breakfast of eggs toat.	te s in the s in the the l l l l l l l l l l l l l l l l l l l	02/27/2015

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIIII	LDING	00	COMPL	ETED
			A. BUII B. WIN			02/06/	2015
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			16TH ST		
CROWN	POINTE OF INDIAN	NAPOLIS			APOLIS, IN 46219		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	the facility sprin	kler system burst,			and sausage on 1/10/15 the		
	flooding the kitchen and portions of the				residents did enjoy the meal		
	first floor. She indicated the kitchen				however we were unable to ge everyone served in a timely	ŧl	
	suffered extensive	ve damage rendering it			fashion so we reverted to the		
		se and requiring major			cold cereal. We tried to		
	renovation, including removal and repair of all food preparation equipment, removal and replacement of drywall, and extensive repairs to electrical and				serve other items such as a		
					breakfast casserole of differen		
					varieties and the response from		
					the residents was not favorable So we again revert to our	e.	
					cold breakfast. I understand the	nat	
	plumbing services. She indicated that				the residents want their hot	iat	
	estimates to return the kitchen to service				breakfast with their eggs made	e to	
	were 6 to 8 weel	KS.			order with their bacon and		
					sausage and toast, but with ou		
	The HFA indica	ted a temporary kitchen			limited facilities at this time we		
	had been establis	shed in a vacant room on			have been unable to prepare of		
	the second floor	. This was observed on			the cook stove top made to orditems and be able to package		
		A.M., and consisted of a			deliver them to the rooms in a	and	
		ic refrigerator and stove,			timely fashion with the items		
		_			holding appropriate temperatu	re	
		nration counter. The			and the resident has not taken		
		d to use their walk in			the breakfast casseroles that v		
		er which had remained in			served So our best option give		
	service without i	interruption.			the circumstances was the choose whole grain cereals, rolls, ju		
					milk and the Quaker oatmeal		
	The HFA indica	ted that, due to the			squares The resident has had	la	
	inability to use the	he facility's kitchen, and			good hot meal served everyda	ıy	
	the limited food	preparation capabilities			for lunch and alternating hot a		
		kitchen, the facility			cold for dinner just as the norn	nal	
		ents with their primary			menu would we are also delivering additional items dail	V	
	_	obtain pre-cooked and			with their evening meal for the	-	
		which could be heated in			evening snack again they hav		
		en. She indicated that			always had the high protein		
					choices of cottage cheese,		
		changed to reflect the			peanut butter sandwich or a fro		
		foods. She indicated she			cup I have attached to modifie		
	was uncertain if	breakfast was limited to			menus have been attached for	r	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED				
			A. BUILDING B. WING		02/06/2015			
NAME OF F	PROVIDER OR SUPPLIEF	3	STREET .	ADDRESS, CITY, STATE, ZIP COL	DE .			
			7365 E 16TH ST					
	POINTE OF INDIAN			IAPOLIS, IN 46219				
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP	CTION (X5) JLD BE COMPLETION			
TAG	`	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE			
		indicated peanut butter		your review There are tw that are normally on our	vo items			
		ches were the alternate		alternative menu that are	e now not			
		ailable. She also indicated		available due to our circu				
	_	ot provide therapeutic or d that residents and		which is a grilled cheese baked potato. In approxir				
	_	ised of that on admission,		one week or less Our kito	chen and			
	and agreed to that.			dining room are schedule				
				up and running and we we back in full force using ou				
	During an interv	view with the Food		normal menus with the fu				
	Service Supervis	sor on 2/05/15 at 1:20		of choices by 2/27/15.				
	P.M., with the H	*						
	indicated the new menus had been							
		on what we had before."						
		dicated breakfast was						
		ereal with milk, juice, bosed to the previous						
		pically included eggs,						
		cream of wheat, and cold						
	cereal options. S	·						
	individual reside	ent assessment had been						
	done to determin	ne personal requirements,						
	requests, or pref	erences based on the new						
	menus.							
	1. The record of	Resident D was						
		6/15 at 9:15 A.M.						
	Diagnoses inclu	ded, but were not limited						
	to, diabetes mell	litus, hypertension, and						
	anemia.							
	Resident D was	interviewed on 2/05/15						
		oncerning food service,						
	nutrition, food q	uality, and menu choices.						
	She indicated the	at as a diabetic she						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	00		E SURVEY PLETED	
			B. WING		— 02/0	6/2015
NAME OF I	PROVIDER OR SUPPLIER	₹		ADDRESS, CITY, STATE, ZIP CO	ODE	
CROWN	POINTE OF INDIAN	NAPOLIS		APOLIS, IN 46219		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	HOULD BE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
		e to make appropriate				
		ne indicated the current				
		ved by the facility				
		nuch pasta. Almost every lly cold breakfast. I can't				
		omething hot." She				
	indicated there v	_				
		-				
	alternatives except peanut butter and jelly sandwiches and stated "I can't eat that."					
She indicated she had to buy her own						
food to have adequate nutrition available.						
	2. The record of Resident E was reviewed					
	on 2/06/15 at 9:4	45 A.M. Diagnoses				
		ere not limited to,				
	hypertension, ce	ellulitis, osteoarthritis, and				
	neuropathy.					
	Resident E was	interviewed on 2/05/15 at				
	9:45 A.M., conc	erning food service,				
	nutrition, food q	uality, and menu choices.				
		The food is just bad. It				
		the kitchen shut down				
		rse. A lot of the time I				
		cold breakfast is the				
		t it. There are no good				
		eve to buy my own food				
	to get by."					
	3. The record of	Resident F was reviewed				
		:15 A.M. Diagnoses				
		ere not limited to,				
		s, hypertension, and				
	neuropathy.	,				
	I		1	1		1

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE COMPL		
ANDILAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUI	LDING	00	02/06/	
			B. WIN			02/00/	2013
NAME OF F	PROVIDER OR SUPPLIEF	3			ACTULOT		
CROWN	POINTE OF INDIAN	NAPOLIS			16TH ST APOLIS, IN 46219		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY		DATE
	8:45 A.M., conc	interviewed on 2/05/15 at erning food service, uality, and menu choices.					
		They're doing the best					
		not good. The same thing					
		breakfast, pasta for lunch					
	a sandwich for d	linner. They offer you a					
	peanut butter sandwich instead but I can't						
	eat that."						
	4. The record of Resident G was						
	reviewed on 2/06/15 at 10:45 A.M.						
	Diagnoses include	ded, but were not limited					
	to, hypertension,	, diverticulitis,					
	osteoarthritis,and	d incontinence.					
		interviewed on 2/05/15					
	•	ncerning food service,					
		uality, and menu choices.					
		They never have any					
		her take what they have					
	or you get nothin	ng. I'm tired of it."					
	5. The record of						
		6/15 at 11:15 A.M.					
	_	ded, but were not limited					
		raumatic brain injury,					
	gastro esophagea osteoarthritis.	al reflux disease, and					
	Resident D was	interviewed on 2/05/15					
		ncerning food service,					
	· ·	uality, and menu choices.					
	numinon, 100a q	durity, and menu enoices.					

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	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/06/2015			
	PROVIDER OR SUPPLIER IPOINTE OF INDIANAPOLIS	STREET ADDRESS, CITY, STATE, ZIP CODE 7365 E 16TH ST INDIANAPOLIS, IN 46219					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OBE COMPLETION			
	She indicated "The food is sometimes good, sometimes not. There are never any choices. I normally eat a hot breakfast but that is not available so I just don't eat breakfast."						
	6. The record of Resident I was reviewed on 2/06/15 at 11:45 A.M. Diagnoses included, but were not limited to, hypertension, constipation, peripheral neuropathy, and anemia.						
	Resident I was interviewed on 2/05/15 at 9:45 A.M., concerning food service, nutrition, food quality, and menu choices. She indicated "My big problem with the food is the breakfast. That was the favorite meal of the day of most residents. With no hot breakfast they just don't get what they want. There are no substitutes. People have to buy their own food to get something they like. I know one resident whose stomach is messed up from cholesterol medications and she can't get the food she needs."						
	During an interview on 2/06/15 at 12:30 P.M., the HFA indicated the facility had no written policy and or procedure related to nutrition and menu preparation but relied on I.S.D.H. published standards for guidance and direction in all nutritional and dietary matters.						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/26/2015 FORM APPROVED OMB NO. 0938-0391

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	. DITH DDIG 00		00	COMPLETED		
			A. BUILDING B. WING		02/06/2015			
	PROVIDER OR SUPPLIEI			7365 E	ADDRESS, CITY, STATE, ZIP CODE 16TH ST APOLIS, IN 46219			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTIO			(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	TE	COMPLETION	
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	This Residential IN 00163773.	tag relates to Complaint						

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